

SECTION 11 SURGERY

PROCEDURE CODES

Missouri Medicaid recognizes the CPT and HCPCS surgery procedure codes and follows the code descriptions listed in the current editions of the publications when reviewing claims. Specific knowledge of the procedures and services performed by the physician is vital in assigning the proper CPT and HCPCS codes. Systems should be in place to correctly transmit information between the physician and the coder.

SURGICAL MODIFIERS

Missouri Medicaid uses the following CPT modifiers for surgical procedures.

- 50 - bilateral procedure
- 54 - surgical care only
- 55 - post operative management only
- 62 - two surgeons
- 80 - assistant surgeon
- SG- Ambulatory Surgical Center only (facility services)

POST-OPERATIVE CARE

Post-operative care includes 30 days of routine follow-up care for those surgical procedures having a Medicaid reimbursement amount of \$75.00 or more. For counting purposes, the date of surgery is the first day.

This policy applies whether the procedure was performed in the hospital, an ambulatory surgical center, or an office setting; and applies to subsequent physician visits in any setting (e.g., inpatient and outpatient hospital, office, home, nursing home, etc.).

Supplies necessary for providing follow-up care in the office, such as splints, casts and surgical dressings in connection with covered surgical procedures, may be billed under the appropriate office supply code. See Section 14 for the list of office supply codes.

INCIDENTAL/SEPARATE SURGICAL PROCEDURES

Surgeries considered incidental to, or a part of another procedure, performed on the same day, are **not** paid separately, but rather are included in the fee for the major procedure. Determine if the surgery is considered incidental by asking yourself if it is a necessary part of the surgery or was the surgery “incidentally” performed, e.g. a laparoscopy that precedes a laparotomy. For information on procedures that are not paid when incidental to other specified services, see Section 13.42 of the Medicaid *Physician Provider Manual*.

Separate procedures are defined as a service performed independently of, and is not immediately related to other services. When performed alone for specific and documented purposes, it may be reported. The procedure should not be billed unless it is performed by itself or is not immediately related to other services being performed during the same session.

MULTIPLE SURGICAL PROCEDURES

Multiple surgical procedures performed on the same recipient on the same date of service by the same provider for the same or separate body systems through separate incisions are to be billed out separately for each procedure. The important factor in coding multiple surgical procedures is to list the surgeries in order of importance or significance for payment, not necessarily always listing the most time consuming procedure first. Claims for multiple surgeries are reimbursed according to the following:

- 100% of the allowable fee for the major procedure
- 50% of the allowable fee for the secondary procedure
- 25% of the allowable fee for the third procedure

An operative report must always accompany claims with multiple surgical procedures on the same recipient on the same date of service.

ASSISTANT SURGEON

Missouri Medicaid adheres to guidelines set by Medicare services for assistants at surgery.

Information on Medicare's guidelines for assistant surgeons is found in the Medicare Services Newsletter, "Indicators/Global Surgery Percentages/Endoscopies", at <http://www.medicare.com/provider/provnewslet/newsindex.asp>. You must accept the **License for Use of "Physicians' Current Procedural Terminology", Fourth Edition (CPT)** agreement at this website before the information can be viewed. The indicator assigned to each surgical code is found in column A of the Surgery Indicator Table.

Examples found in Column A include:

- Some procedures do not require an assistant surgeon (Assistants at surgery are never paid for these procedures.)
- Assistant at surgery is paid (No payment restriction applies.)
- Payment restriction for assistants at surgery applies; a *Certificate of Medical Necessity* form is required (These procedures do not normally require an assistant surgeon but with medical necessity will be considered for payment.)

Note - Not all codes in the listing are covered by Missouri Medicaid; refer to the Missouri Medicaid fee schedule at **www.dss.mo.gov/dms** for coverage information.

The medical necessity for the assistant at surgery must be fully documented on the *Certificate of Medical Necessity* form. The form must include the assistant surgeon's name, provider number, and signature. Instructions for completing the *Certificate of Medical Necessity* form are in Section 7.2 of the Missouri Medicaid *Provider Manual*.

CO-SURGERY

"Co-Surgeons" are defined as two primary surgeons working simultaneously performing distinct parts of a total surgical service, during the same operative session. Each physician should submit separate claims, using his/her own individual/clinic Medicaid provider number. The surgical procedure code together with modifier "62" should be shown on both claims. The name of both surgeons must appear on the claim form in the "description" area (field 24d on the CMS-1500), with a description of the entire (total) procedure performed. An operative report must be attached to each claim and the operative report should justify the necessity of two surgeons. These claims cannot be billed electronically and are manually priced by the medical consultant.

CONSULTATIONS

A consultation is when a physician renders an opinion or advice at the request of another physician. It is **not** a referral of a patient to another physician for care and treatment. A consultation must always include a written report sent back to the requesting physician. The written report must include all findings, the opinion of the consulting physician, and advice or recommendations for patient treatment. When a consulting physician begins to "treat" rather than advise on treating, then it ceases to be a consultation. At that time, the consulting physician becomes an attending physician for the patient and should use appropriate levels of service codes based on the place of service.

CONSULTATION CODES

Office/Outpatient Consult Codes

99241
99242
99243
99244
99245 (requires a copy of the consult
report with the claim)

In-patient Consult Codes

99251
99252
99253
99254
99255 (requires a copy of the consult
report with the claim)

Follow-up inpatient consultations (CPT codes 99261-99263) are visits to complete the initial consultation or subsequent visits requested by the attending physician.

SECOND SURGICAL OPINION

The intent of the Second Surgical Opinion Program is to provide an eligible Missouri Medicaid patient with a second opinion as to the medical necessity of certain elective surgical operations. When the second opinion has been obtained, regardless of whether or not it confirms the primary recommendation for surgery, the final decision to undergo or forego elective surgery remains with the Medicaid patient. A list of the procedure codes requiring a second surgical opinion appears later in this section.

The Second Surgical Opinion form contains four sections and must be completed in the following manner:

Section I This section is completed by the physician recommending surgery. The appointment date in this section must be the date the patient was seen by the physician recommending surgery.

Section II Completed by the second opinion physician. A second opinion must be obtained within **60 days** after the primary recommendation appointment date in Section I of the form. When rendering a second opinion, the physician should bill a procedure code in the range of 99271-99274.

Section III Completed by the third opinion physician. A third opinion must be obtained within **60 days** after the second opinion appointment date in Section II. A third opinion is allowed by Missouri Medicaid if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical operation. When rendering a third opinion, the physician should bill a procedure code from the range 99271-99274.

Section IV Completed by the surgeon. Surgery must be performed within **150 days** of the first appointment date in Section I. Section IV should be completed and signed by the surgeon any time on or after the date of surgery. It is the surgeon's responsibility to furnish the hospital or ambulatory surgical center with a copy of the completed second opinion form.

Staff interns, residents, and nurse practitioners are **not** permitted to provide the first, second, or third opinion.

Note – Anesthesiologists, assistant surgeons, independent laboratories, and independent x-ray services are exempt from the requirement to submit a copy of the Second Surgical Opinion form with a claim for services.

EXCEPTIONS TO SECOND OPINION REQUIREMENT

- Medicare/Medicaid crossover claims are exempt.
- The Second Surgical Opinion form is not required if the surgeon does not participate in the Missouri Medicaid Physician Program. This must be stated in field 19 of the CMS-1500 claim form and the physician's full name listed.
- Those surgical operations specified are exempt from the second surgical opinion requirement if any one of them is performed incidental to a more major surgical procedure that does not require a second surgical opinion.

- If the service was performed as an emergency and a second opinion could not be obtained prior to rendering the service, complete the claim form and enter “emergency” in field 19 of the CMS-1500. Attach a *Certificate of Medical Necessity* form (or other adequate documentation such as operative notes, admit or discharge summaries, etc.) to the claim. The provider must state on the *Certificate of Medical Necessity* form, in detail, the reason for the emergency provision of service.
- If the recipient was not eligible for Medicaid at the time of service, but was made retroactive to that time. If the provider is unable to obtain an eligibility approval letter from the recipient, the claim may be submitted with a completed *Certificate of Medical Necessity* form indicating the recipient was not eligible at the time of service but has become eligible retroactively to that date. (See Section 7 of the Missouri *Medicaid Provider Manual* for information on completing the *Certificate of Medical Necessity* form.) If the eligibility approval letter or the *Certificate of Medical Necessity* form is not submitted, the claim will be denied.

SURGERY CODES THAT REQUIRE A SECOND OPINION

Effective for dates of service July 1, 2005 and after, only the following six procedure codes require the submission of a Second Surgical Opinion form.

66840 - removal of lens material aspiration technique, one or more stages
66850 - removal of lens material phacofragmentation technique
66852 - removal of lens material; pars plana approach, with or without virectomy
66920 - removal of lens material; intracapsular
66983 - intracapsular cataract extraction with insertion of intraocular lens prosthesis- one stage procedure
66984 – extracapsular cataract removal with insert, intraocular lens prosthesis- one stage procedure, manual or mechanical technique.

The procedure codes on the following page require a second surgical opinion and the submission of a “Second Surgical Opinion” form for dates of service prior to July 1, 2005. Procedure codes marked with an “*” also require the submission of an “Acknowledgment of Hysterectomy Information” form.

28290	49500-62	51925*	58294-62*	63040-6250	63091-62
28290-50	49500-6250	51925-62*	58550	63042	63180
28292	449505	57240	58550-62*	63042-50	63180-62
28292-50	49505-50	57240-62	58552*	63042-62	63182
28292-62	49505-62	57250	58552-62*	63042-6250	63182-62
28292-6250	49505-6250	57250-62	58553*	63045	63185
28293	49520	57260	58553-62*	63045-62	63185-62
28293-50	49520-50	57260-62	58554*	63046	63190
28293-62	49520-62	57265	58554-62*	63046-62	63190-62
28293-6250	49520-6250	57265-62	58951*	63047	63191
28296	49525	58120	58951-62*	63047-62	63191-50
28296-50	49525-50	58150*	58953*	63048	63191-62
28296-62	49525-62	58150-62*	58953-62*	63048-62	63191-6250
28296-6250	49525-6250	58152*	58954*	63050	63194
28297	49550	58152-62*	58954-62*	63051	63194-62
28297-50	49550-50	58180*	59525*	63055	63195
28297-62	49550-62	58180-62*	59525-62*	63055-62	63195-62
28297-6250	49550-6250	58200*	63001	63056	63196
28306	49555	58200-62*	63001-62	63056-62	63196-62
28306-62	49555-50	58210*	63003	63057	63197
28308	49555-62	58210-62*	6300-62	63057-62	63197-62
28308-62	49555-6250	58240*	63005	63064	63198
47562	49560	58240-62*	63005-62	63064-62	63198-62
47562-62	49560-50	58260*	63011	63066	63199
47563	49560-62	58260-62*	63011-62	63066-62	63199-62
47563-62	49560-6250	58262*	63012	63075	66840
47564	49565	58262-62*	63012-62	63075-62	66840-50
47564-62	49565-50	58263*	63015	63076	66850
47600	49565-62	58263-62*	63015-62	63076-62	66850-50
47600-62	49565-6250	58267*	63016	63077	66852
47605	49570	58267-62*	63016-62	63077-62	66852-50
47605-62	49570-50	58270*	63017	63078	66852-62
47610	49570-62	58270-62*	63017-62	63078-62	66852-6250
47610-62	49570-6250	58275*	63020	63081	66920
47612	49580	58275-62*	63020-50	63081-62	66920-50
47612-62	49580-62	58280*	63020-62	63082	66920-62
47620	49585	58280-62*	63020-6250	63082-62	66920-6250
47620-62	49585-62	58285*	63030	63085	66983
49491	49650	58285-62*	63030-50	63085-62	66983-50
49491-50	49650-50	58290*	63030-62	63086	66984
49491-62	49650-62	58290-62*	63030-6250	63086-62	66984-50
49491-6250	49650-6250	58291*	63035	63087	
49495	49651	58291-62*	63035-50	63087-62	
49495-50	49651-50	58292*	63035-62	63088	
49495-62	49651-62	58292-62*	63035-6250	63088-62	
49495-6250	49651-6250	58293*	63040	63090	
49500	49659	58293-62*	63040-50	63090-62	
49500-50	49659-50	58294*	63040-62	63091	